Q&A Session for Pancreas 2021

May 10, 2021

#	Question	Answer
1.	For hospital-based registries, what would be a good measure to take to ensure that the highlighted missed histologies are picked up during case finding?	Most of them should show up on pathology reports. I think that is where i would focus my efforts.
2.	Would you code these palliative surgeries? Would you code in palliative field or bypass in diagnostic & staging procedure?? Both? Not at all??	Based on post in the CAnswer forum stent placement and a by-pass would be coded as palliative if it is clear that the intent was pain relief.
3.	Are we not to code palliative according to "intent" of treatment? Is this different because this is pancreas site?	That is my impression based on posts on the CAnswer forum.
4.	If you know there is lymphadenopathy but don't know the number of lymph nodes involved, wouldn't it be NX?	As a registrar you would leave the N field blank. A physician would use a NX if the physician doesn't have enough info to assign a value.
5.	Question for cN blank in Case #1...if registrar has clinical documentation available but the information to assign T and/or N categories cannot be assessed/determined, could we assign cNx instead of cN blank?	cN would be the appropriate value.
6.	I have great post about X or BLANK.. dated 03-26-2021 http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/lower-gastrointestinal-tract-chapters-19-21/colon-and-rectum-chapter-20/114814-rectal-uncertain-clinical-t-and-group-stage In a nutshell by leaving it blank, it is sending a different message to the physicians using the data. It is telling them that the	Thank you!

	physicians were able to assess this tumor, but either did not document it for registrars, or the documentation wasn't clear enough or specific enough to assign the category.... the X should only be used when the physician states, they cannot assess the tumor at all, have no idea what the T category is.	
7.	I was thinking that to have a yc stage the planned surgery had to be cancelled or not needed according to Donna Gress's presentation AJCC yc how and when to use. As registrars, can we assign the yc stage even if yp stage is applicable?	You are not required to assign yc if surgery is done, but you can.
8.	The pancreatic endocrine tumor, nonfunctioning has been a /3 since 2012. Should the topography be c25.4 Islets of Langerhans for the NET's ?	Per the SEER post below, Islet cell carcinoma should be coded to C25.4. I am not aware of instructions to code all neuroendocrine tumor of the pancreas to C25.4, but I would submit the question to SEER. https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20031137&type=q
9.	Does Clinical T4 "involvement" include circumferential involvement (abutment/encasement as described on page 341), or only "invasion" of those arterial structures?	T4 should only be based on the arteries defined as T4 in the category.
10.	And if so, is there any difference when assigning the T whether it is 5 degrees of abutment vs 100 degrees of abutment vs circumferential abutment?	I have not seen a radiology report where they describe contact at that level of detail. Usually, it is either less than 180 or more than 180. As far as I can tell if there is any area the radiologist describes as abutment, a T4 can be assigned.
11.	Do you code stent placement in treatment? And if you do, how is it coded? I assume a bypass would be in the diagnostic/staging procedure 06?	Based on CAnswer forum posts the stent placement and by-pass can be assigned as a code 7 under palliative if is clear the intent was palliative.
12.	Scenario 1, wouldn't extension to retroperitoneal soft tissue be distant Summary Stage?	Yes.

13.	If there is hormone therapy or Immunotherapy with the chemo, don't we need to code those also?	You would, but that was not the case in these scenarios.
14.	Did not think we did 99 on Path stage if had yp stage?	Path stage group should never be blank.